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(f) For purposes of setting the maximum rate per visit for hospital-based agencies, the Department has established two subcategories: Urban hospital-based and rural hospital-based. The maximum rate per visit for each agency in these subcategories is determined by adding a hospital-based adjustment amount to the freestanding urban and freestanding rural based rate ceilings. The adjustment is calculated as follows:

The mean of the agencies' inflated base period cost per visit will be calculated for each of the subcategories. A percentage of the mean for each subcategory will be calculated and added to the base rate ceiling for the corresponding freestanding urban or rural category, plus the supply rate to establish the maximum rate for hospital-based agencies in that subcategory.

Each hospital-based agency will be reimbursed the lesser of its rate calculated as noted in paragraphs (a) through (d), or the maximum rate per visit for its subcategory.

Assignment to a subcategory is determined according to the criteria outlined in the section labeled classification of agencies.

(g) Reimbursement rates will be adjusted for home health agencies which provide certain home-delivered services to community-care recipients. The rate adjustment will be calculated using the home health reimbursement methodology in paragraphs (a) through (f) above, and the calculation will include both home health and home delivered services utilization data for the base period.

Reimbursement rates will be adjusted only for those agencies currently enrolled and providing services in the community care home-delivered services program and for which at least nine months of cost and utilization data exists for the base period. Home health agencies which discontinue

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the provision of home-delivered services will be subject to a reduction in their reimbursement rate.

(h) Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on all home health visits. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are also exempt from a co-payment.

Cost Reports

Each agency must submit a copy of its as-filed Medicare cost report and a completed Medicaid Cost Data Form (supplied by the Department) to the Department. These documents must be received by the Department within one hundred fifty (150) days after each agency's fiscal year end. If the Medicare and Medicaid reports have not been received after this one hundred fifty (150) day period, a rate reduction of 10% on the current rate will be imposed. This rate reduction will remain in effect through the final day of the month in which the cost information is received. If the information is received after any fraction of a month beyond the one hundred fifty (150) day period, the rate reduction of 10% will be applied for the entire month. If an agency's cost information is not received by the time the Department establishes individual provider rates and determines the percentiles and rate ceilings, that agency will be assigned the lesser of its current rate or the lowest rate in the State for the appropriate category, less applicable incentive, as established by the rate-setting process. If the agency's cost information is received after rates are established, the Department will calculate a rate based on the

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information received and retroactively and prospectively adjust the agency's previously assigned rate only if it is greater than the calculated rate. The agency's rate will remain in effect until the next rate adjustment period, as determined by the Department. Failure to submit cost information may result in suspension or termination of the agency from the Medicaid Home Health program.

An agency's Medicaid cost report is subject to review or audit by the Department or its agent(s) in accordance with HCFA-15 principles of reimbursement and Medicaid policies and procedures. The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the administrative review procedures outlined in the home health policy manual.

Nonallowable Costs

Effective for the determination of reasonable costs used in the calculation of rates initially established on and after April 1, 1991, the costs outlined below are nonallowable for Medicaid purposes:

(a) Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

(b) Memberships in civic organizations;

(c) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

(d) Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g., ambulances);

(e) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient transport is nonallowable;

(f) Fifty percent (50%) of professional dues for national, state, and local associations.

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(g) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable.

(h) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying.

Information on these nonallowable costs will be obtained by the Department or its agent at the time of review or audit of the agency.

The agency's reimbursement rate will be adjusted (if necessary) for the period for which the rate was effective as a result of the review or audit performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting therefrom using the Department's Administrative Review Procedures.

New Agencies

a) A new agency will be reimbursed a rate equal to the statewide average reimbursement rate for the appropriate category, as of the effective date of enrollment of the new agency. This new agency rate will be reimbursed until a cost report for a base period (minimum nine months) on which an agency-specific rate per visit can be based, is received by the Department. There will not be a cash settlement determination for new agencies.

b) A new agency is defined as an agency established by the initial issuance of a Certificate of Need (CON), Medicare certification and state license; it is reimbursed as described in paragraph a) above. An agency formed as a result of a merger, acquisition, other change of ownership, business combination, etc. is not a new agency. Each agency of this type will maintain the reimbursement rate it was assigned prior to the transaction. When rates are subsequently adjusted, the appropriate cost report for the base period (as determined by the Department) will be used as a basis for determining the agency's rate.

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Agencies With Insufficient or Unauditable Cost Data

If an existing agency submits costs data for its fiscal year that corresponds to the base period and the fiscal year is for an insufficient period of time (as determined by the Department but usually a period of less than nine (9) months), that cost data will not be used in establishing the percentile and rate ceilings for the appropriate category and in calculating the statewide supply rate per visit. However, the data will be used to calculate a rate per visit using the methodology previously described. A freestanding agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the 75th percentile for the appropriate category, calculated exclusive of the agency's insufficient cost data, plus the statewide supply rate per visit, also calculated exclusive of the agency's insufficient cost data. A hospital-based agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the maximum rate per visit for the appropriate hospital-based subcategory, calculated exclusive of the agency's insufficient cost data, plus the supply rate per visit, also calculated exclusive of the agency's insufficient cost data. There will be no cash settlement for existing agencies with insufficient cost data for the base year.

Existing agencies with cost data which cannot be audited for the fiscal year that corresponds to the base period will be omitted from the rate setting process and assigned the lowest rate in the state for the applicable category until the appropriate records are made available to verify (audit) the cost information.

Amended Medicare and Medicaid Cost Data

An agency may submit an amended Medicare cost report and Medicaid Cost Data Form after the initial submission for the most recent fiscal year. An amended report and cost data form must be received by the Department no later than ninety (90) days after the due date of the initial report and form, or ninety (90) days after any due date extension granted by the Department. The amended Medicare report must support the amended Medicaid cost data form. The due date of the initial report and cost data form is contained in the cost report section.

Classification of Agencies

For reimbursement purposes Home Health agencies will be classified as follows:

(a) Urban - Agency located in a Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

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(b) Rural - An agency located in a non-Metropolitan Statistical Area, as evidenced by documentation on file with the Department, including, but not limited to, the address on the Medicare cost report received by the Department or fiscal intermediary.

(c) Hospital-based - An agency classified as hospital-based for Medicare purposes will be considered hospital-based for Medicaid purposes. Hospital-based agencies will be further categorized as urban or rural using the criteria in (a) and (b) above. Agencies retrospectively classified as hospital-based by Medicare will not be classified retrospectively as hospital-based by the Department. The agency will be notified of the prospective effective date.

Agencies which submit Medicare cost reports with addresses different from the address on the Statement of Participation on file with the Department will have their cost reports returned for verification. If the agency uses the address on the Medicare cost report for Medicare purposes, this same address will be utilized in designation of a location for rate setting purposes for the Department.

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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

H. INDEPENDENT LABORATORY AND X-RAY SERVICES

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) the actual charge for the procedure, or

(b) the statewide rate in effect on the date of service.

Reimbursement for laboratory services performed by an independent laboratory will not exceed the upper limit of payment established by Medicare for the same clinical laboratory test.

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I. Orthotics and Prosthetics Services

The maximum reimbursement amount for items and services will not exceed rates established by the State Agency based upon the usual and customary charge for the items and services.

Effective for dates of service July 1, 1994, and after, a $3.00 recipient co-payment is required on Orthotics and Prosthetics services.

Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice services are not required to pay a co-payment. Emergency services and family planning services are also exempt from a co-payment.

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J. Physician Services (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The actual charge for the services; or

(b) The statewide rate in effect on the date of services.

(c) If the recipient is referred in writing by the surgeon to an optometrist for post-cataract surgery follow-up care, the surgeon's fee will be reduced by and amount equal to the maximum allowable reimbursement for the post-cataract surgery follow-up care.

Payments for certain services rendered in a hospital setting which are normally performed in a physician's private office or clinic are made on a statewide basis and are limited to the lower of:

(a) The actual charge for the service; or

(b) Sixty-five percent (65%) of the statewide rate in effect on the date of service.

Payments for certain services rendered in a physician's office, private clinic, or a free-standing ambulatory surgical center rather than in a hospital setting are made on a statewide basis and are limited to the lower of:

(a) Twenty-five dollars ($25) above actual charge or statewide rate when the statewide rate is less than $100.

(b) Twenty-five percent (25%) above actual charge or statewide rate when the statewide rate is $100 or more.

Payments to physicians for certain services performed by physician's Certified Physician's Assistants are made on a statewide basis and are limited to the lower of:

(a) The submitted charge; or

(b) 90% of the statewide rate for physician services in effect on the date of service.

Payments to physicians for anesthesia services performed by Physician's Assistant Anesthesiologist Assistants (PAAA) are made based on the statewide reimbursement rate in effect for medically directed Certified Registered Nurse Anesthetists at the time services are rendered, or the submitted charge whichever is lower.

Effective with dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all non-emergency evaluation and office visits for physician and podiatrist providers; a $2.00 rcipient co-payment is required for all ophthalmology service visits; a $1.00 recipient co-payment is required for all optometric service visits. Pregnant women, recipients under twenty-one years of age, hospice care recipients and nursing home residents are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment.

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K. Nurse-Midwife Services

Payments are limited to the lower of:

(a) The submitted charge; or

(b) The statewide rate in effect on the date of service.

L. Rural Health Clinic Services

As established by 42 CFR 447.371, payment for clinic services will be based on a reasonable cost rate per visit as determined by Medicare. Other ambulatory services will be reimbursed at a rate set for each service by the agency. Cost settlements will be made.

M. Non-Emergency Transportation Services

Non-emergency transportation is reimbursed according to the following methods, depending on type of vehicle and number of passengers. Upper reimbursement limits shall not exceed charges determined to be reasonable by the state.

(a) Base rate plus loaded recipient mileage for non-emergency ambulance one-way passenger trips; base rate plus loaded recipient mileage in excess of 10 miles for minibus one-way passenger trips; base rate plus loaded recipient mileage in excess of 10 miles for wheelchair van one-way passenger trips; and base rate plus loaded recipient mileage in excess of 20 miles for wheelchair van round trips. For minibus and wheelchair van trip mileage less than or equal to the above thresholds, only a base rate is reimbursed.

(b) Mileage rate per passenger for automobile services.

(c) Commercial and public transportation are reimbursed at usual and customary rates.

N. Case Management Services

(a) MH/MR/SA

Case Management services will be reimbursed on a negotiated rate basis not to exceed actual costs, which meets all requirements of the Office of Management and Budget Circular A-87 dated January 15, 1981.

(b) Perinatal Case Management Services will be reimbursed on a fee-for-service basis billed monthly on the HCFA 1500 form.

For private providers, payments are limited to the lesser of the submitted charge or the established fees as determined for public providers below.

Fees-for-service will be prospective, based on the actual cost of public providers and will be evaluated annually to reflect actual cost.

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